Chestnut Green
DENTAL • GROUP

PATIENT INFORMATION

Date
Patient Name
Address
City State Zip
Best way to contact you: H W C Phone E-mail Text Message
Home Phone No.
Work Phone No.
Cellular Phone No.
E-mail Address
Birthdate Age Male ☐ Female ☐
Social Security Number
Married ☐ Single ☐ Divorced ☐ Widowed ☐
Employer Position
School

DENTAL INSURANCE
PRIMARY DENTAL CARRIER
Insurance Co.
Subscriber Birth date
Subscriber
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

SECONDARY DENTAL CARRIER
Insurance Co.
Subscriber
Subscriber Birth Date
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

Emergency Contact Information:
Name
Relationship
Phone Number
Address
City State Zip

Responsible Party
Address
City State Zip
Responsible Party Social Security Number

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

_____
Patient Date

_____
Parent or Guardian Relationship

_____
Patient or Guarantor's Signature

We accept MasterCard, Visa, Discover and Amex